

# HealthPOWER!

## Prevention News

Veterans Health Administration

September 2005



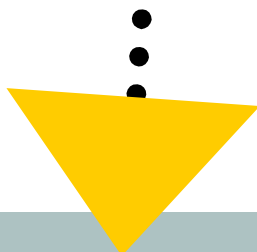
*"Change is the law of life. And those who look only to the past or present are certain to miss the future."*

*- John F. Kennedy, 35th President of the United States*

### What's Inside:

New Assistant Director, Field Operations .....	Page 4
Freedom Walk .....	Page 6
Preventing Long Term Homelessness Using Work Therapy .....	Page 8
MOVE! Success Stories .....	Page 9
Warned, But Worse Off .....	Page 10

## What's on NCP's Calendar



### Calendar of Events

#### Past

- \* PM Conference Call—September 13, 2005
- \* General Wellness Conference Call—September 27, 2005
- \* Worksite Wellness Conference, Tampa, FL—September 30, 2005

#### Future

- \* NCP presentation at National Meeting of Society for Obesity (NAASO) - October 2005
- \* PM Conference Call—October 11, 2005
- \* PM Conference Call—November 8, 2005
- \* Employee Wellness Advisory Council Conference Call—October 25, 2005
- \* Employee Wellness Advisory Council Conference Call—November 22, 2005

#### **MOVE! Program Rollout**

- \* October—Online **MOVE!** Training
- \* December—**MOVE!** Toolkit Mail Out
- \* January—**MOVE!** Program Implementation

#### Prevention Topics

- \* September—Influenza/Pneumococcal  
([http://vaww.nchpdp.med.va.gov/MPT\\_2005\\_09.asp](http://vaww.nchpdp.med.va.gov/MPT_2005_09.asp))
- \* October—Depression Screening  
([http://vaww.nchpdp.med.va.gov/MPT\\_2005\\_10.asp](http://vaww.nchpdp.med.va.gov/MPT_2005_10.asp))
- \* November—Tobacco  
([http://vaww.nchpdp.med.va.gov/MPT\\_2005\\_11.asp](http://vaww.nchpdp.med.va.gov/MPT_2005_11.asp))
- \* December—Alcohol/Substance Abuse

### VA National Center for Health Promotion and Disease Prevention

#### NCP Staff

**Steven J. Yevich, MD, MPH**  
Director

**Mary B. Burdick, PhD, RN**  
Chief of Staff

**David A. Pattillo, MHA**  
Assistant Director, Center Operations

**Pamela Frazier, BS**  
Staff Assistant

**Kraig Lawrence**  
IRM

**Richard T. Harvey, PhD**  
Assistant Director, Preventive Behavior

**Kenneth Jones, PhD**  
MOVE! Program Manager

**Linda Kinsinger, MD, MPH**  
Assistant Director, Policy, Programs,  
Training, and Education

**Pamela Del Monte, MS, RN, C**  
Assistant Director, Field Operations

**Rosemary Strickland, APRN, BC**  
Special Projects Coordinator

**Connie F. Lewis**  
Program Analyst

#### Contract Services

**Michael K. Anderson**  
Program Assistant

**Tracey L. Bates, MPH, RD, LDN**  
Dietitian, MOVE! Program

**Karen Crotty, PhD**  
MOVE! Project Coordinator

**John Elter, PhD, DMD**  
Epidemiologist

**Leila Kahwati, MD, MPH**  
Preventive Medicine Physician

**Susi K. Lewis, MA, RN**  
MOVE! Project Coordinator

**Jean G. Orelie, MS**  
Biostatistician

**Bryan Paynter**  
IT  
**Tony Rogers**  
IT

#### Address and Phone:

3022 Croasdaile Drive, Suite 200  
Durham, NC 27705  
919-383-7874 (phone)  
919-383-7598 (fax)

Address suggestions, questions and comments  
to the Editorial Staff:

Connie Lewis, ext. 233  
Rosemary Strickland, ext. 239

### NCP Mission Statement

The VA National Center for Health Promotion/Disease Prevention (NCP) is the central resource for "All Things Prevention," to include: prevention information, prevention education and training, prevention research, and prevention recommendations for the VHA. The Center facilitates the improvement and availability of prevention services in order to reduce illness, death, disability, and cost to society resulting from preventable diseases.

## From the Chief of Staff...

Mary B. Burdick, PhD, RN

### Leadership Transition at the NCP

**O**n this day in late September, we would like to share this tribute to Steven J. Yevich, M.D., M.P.H. Dr. Yevich's brilliant vision, leadership and passion for preventing and mitigating progression of existing disease through evidence-based screening and treatment will benefit veterans for many years to come.

Dr. Yevich is leaving the Center at the end of this month, having served as Director of the National Center for Health Promotion and Disease Prevention (NCP) from 8/2001 through

9/2005. His leaving punctuates a remarkable four-year era of breathtaking growth at NCP having started in 2001 with only 5 staff and little national recognition of the office, and ending this month with 20 staff. During Dr. Yevich's tenure as Director he has transformed the NCP into a robust and highly productive "national Center" that has achieved significant national impact both within and outside of the VA.

His "door was always open" and his heart was always with those on the front lines who deal with patient care issues day in and day out. He never ceased to be amazed by the creativity of field staff who rely on their own energy and enthusiasm to come up with innovative programs, activities, events and solutions to meet prevention needs of

veterans. To his credit, VHA now has in place a fully functioning prevention infrastructure. Prevention Champion Individual and Team awards (a plaque and cash award) have provided recognition and motivation for deserving staff in the field, both Clinical and Administrative. Silver Star awards were initiated to recognize the critical role of leadership support for the Prevention Champions.



A Preventive Medicine Field Advisory Council, made up of the VISN Preventive Medicine Leaders from all 21 VISNs, has been convened, ensuring leadership and coordination throughout the VA health care system. Prevention manuals, a widely acclaimed website, bi-

monthly newsletters, a prevention training course, and communication among sites and with NCP have been developed. Every VISN and medical center has a Prevention Coordinator (PC). Formal training for PCs was provided in two, three and one half day intensive prevention training courses. Through Dr. Yevich's efforts, interest in employee wellness has grown and organized national efforts are now underway.

Dr. Yevich has worked tirelessly to promote important prevention issues for veterans and has led the Center to focus on behavior as the foundation for prevention. The NCP website has given veterans access to scientifically accurate, prevention information. The NCP generates patient

*(Continued on page 4)*

(Continued from page 3)

handouts on important preventive health topics for the facilities to distribute to patients every month. The Flu/Pneumococcal Toolkit was created and standardized delivery of the best evidence-based practices to maximize immunization rates in VHA. The *MOVE!* national VA weight management/physical activity program is a truly ambitious, national, comprehensive program that will benefit approximately four million veteran patients and their families. This program will be the largest weight management program associated with a medical care organization in the country. He formed a VA Weight Management Executive Advisory Council comprised of national experts who have reviewed, provided assistance with development and endorsed the *MOVE!* Program.

Dr. Yevich established a VHA prevention research initiative, best exemplified by three NCP initiatives. The annual VA Flu Toolkit evaluation gathered feedback on usefulness and effectiveness from patients and VA clinicians via a series of internal surveys and the Patient Satisfaction survey (SHEP).

Findings were used each year since inception in 2002 to revise and improve the toolkit. A Veterans Health Survey (VHS) was proposed to provide data to enable VHA to design achievable, scientifically current prevention strategies tailored to meet the needs of veterans in accordance with the Congressional VA Prevention mandate. In addition, a dynamic ongoing evaluation of *MOVE!* has been developed to guide future refinements of this wide-reaching national program. Other research projects have been completed as well.

His dedication and commitment to VA's mission of service to veterans was evidenced in many ways, among these were his efforts to prepare VHA for a wider focus whereby prevention of disease in veterans is accorded equal emphasis with illness care. Dr. Yevich's legacy will live on through the initiatives of NCP and everyday actions of VA preventionists in the field.

The NCP will soon enter a new era of growth, building on the Center's current hard-fought and hard-earned place of prominence in the VHA. As of this writing, approval of a new Center Director is proceeding through the usual process and will be forthcoming.

### *New Assistant Director for Field Operations*

The NCP is delighted to introduce Pam Del Monte, MS, RN, C., new Assistant Director for Field Operations. She has been with the VA for 3 years, most recently as the Clinical Director for Primary and Ambulatory Care at the VAMC in Washington DC. Prior to that, she was a Clinical Coordinator for specialties and primary care at Kaiser Permanente. While in DC, Pam was instrumental in improvements the medical center made in the colorectal cancer screening rates. She also was responsible for starting nurse-run hypertension classes, coordinating those patient education materials and standardizing the clinical nurse blood pressure follow-up appointments. She also coordinated the medical center's immunization efforts. Other clinical endeavors included the decentralization and expansion of the Medical Advice Function and the triage function in the primary care clinics. Pam received her basic nursing education at St. Vincent's Hospital School of Nursing in New York City. She received her BS from Long Island University, C. W. Post and her MS from Adelphi University in Garden City, NY. She holds ANCC certification as an Ambulatory Care Nurse. Pam is currently the Program planning co-chair for the American Academy of Ambulatory Care Nurses (AAACN) 2006 annual conference. She will chair program planning for the 2007 conference. She has also chaired AAACN's Membership Council. Pam was a content reviewer and an author for the first edition of the Core Curriculum for Ambulatory Care Nursing. New to North Carolina, Pam is spending her spare time sampling the myriad of golf courses in the area. Pam is looking forward to establishing communication with each of you. Please feel free to contact her on Outlook or by telephone at (919) 383- 7874, ext. 235.





## Ask Dr. Linda...

### Influenza Update

On Sept. 2, CDC published in the MMWR an update on influenza vaccine supply and recommendations (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5434a4.htm>).

Four manufacturers expect to provide influenza vaccine to the US this flu season – 3 makers of trivalent inactivated vaccine (TIV – “flu shot”) and 1 maker of live attenuated influenza vaccine (LAIV – “nasal spray”). The VA supply has been ordered from sanofi pasteur, as in years past; they expect to produce between 50 and 60 million doses of TIV. All ordering facilities will receive a partial shipment by October 15, 2005, with the balance to be completed by December 31, 2005. GlaxoSmithKline plans to make around 8 million doses and Chiron will make 18-26 million doses if they get all the approvals needed. MedImmune will make 3 million doses of LAIV.

Given uncertainty in doses and distribution, CDC recommends the following priority groups receive TIV until October 24, 2005:

- Persons aged >65 with or without comorbid conditions
- Residents of long-term care facilities
- Persons aged 2-64 with comorbid conditions
- Pregnant women
- Health care personnel who provide direct patient care
- Note that a new chronic condition has been added this year: persons with any condition that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration should be vaccinated. These conditions include cognitive dysfunction, spinal cord injuries, seizure disorders, and other neuromuscular disorders.

Beginning October 24, 2005, all persons will be eligible for vaccination.

*Follow-up note: On September 22, VA Influenza Vaccine Advisory #2 was issued, stating that VA will*

*follow the above CDC tiered recommendations, with one exception – rather than limited early vaccination only to health care personnel who provide direct patient care, VA will vaccinate all “personnel who work in VA health care facilities.” To see the entire advisory, please go to: [www.publichealth.va.gov/flu](http://www.publichealth.va.gov/flu).*

The VA Influenza Vaccination Toolkit will be sent out in a couple of weeks (before the end of the month). Each prevention coordinator will receive one, along with 7 others at each facility. The toolkit will contain a manual, posters, and buttons and stickers. Watch for Vaccine Advisories as they are issued this fall; one will be coming out soon. They will be posted on the NCP website, as well as the Public Health website (<http://vaww.vhaco.va.gov/phshcg/Flu/advisory.htm>). The Influenza Directive is in the concurrence process and should be ready soon.

A major emphasis of the influenza vaccine campaign this fall is to promote flu shots (or LAIV) for all health care workers. There haven't been exact figures of the percent of VA health care workers who are vaccinated each year, but this year facilities will be asked to provide that information. Nationally, it's less than 40%. Vaccinating health care workers is important for at least 2 reasons:

1. Influenza-infected health care workers can and do transmit deadly influenza virus to their vulnerable patients. A study that compared mortality rates of patients between facilities that vaccinated 51% of workers and others that vaccinated only 5% of workers found a 40% reduction in all-cause mortality among patients cared for by workers in the hospitals with the higher vaccination rate in the employees.
2. Influenza vaccination of health care workers saves money and prevents workplace disruption, caused when many staff are out sick with the flu.

*(Continued on page 6)*

(Continued from page 5)

LAIV is an appropriate choice for many VA health care workers – those under age 50 who are healthy and not pregnant. LAIV is as effective as the TIV (“flu shot”) and is safe. The risk of transmission of live virus is very low. Only health care workers who take care of patients with severely weakened immune systems or who require protective isolation, such as those in bone marrow transplant units, should defer taking LAIV (if otherwise eligible).

There are interim Vaccine Information Statements (VISs) for both inactivated influenza vaccine and live attenuated influenza vaccine (dated 7/18/05). We strongly encourage you to use these VISs for your patients. Under new rules this summer, use of the VISs will be required, once they’re finalized. I contacted someone in the National Immunization Program at the CDC who said he didn’t think the final ones would come out until later this year, so you should use the interim statements in the meantime.

We’ve recently posted 2 new resources on our webpage (<http://vaww.nchpdp.med.va.gov/>) – one is an updated Summary of Adult Immunizations and the other is a listing of the dose, route, site, and needle size for all adult immunizations. Please take a look at those.

### Freedom Walk Submitted by Shirley Redmond VA Sioux Falls, South Dakota



Rita Loving, Gary Million, Associate Director, Maria Wheeler

To commemorate the 4th anniversary of September 11 and to honor our U.S. troops, veterans, and emergency personnel, the Sioux Falls VA Medical Center hosted a *Freedom Walk* September 9.

Ninety six medical center and Dakotas Regional Office employees, veterans, volunteers and visitors participated. Joseph Dalpiaz, Director, granted employees 30 minutes to participate, and bottled water and healthy snacks were provided. The walk was sponsored by the Sioux Falls VA Wellness and Patriot Day Committees.

## Richard T. Harvey, PhD Assistant Director, Preventive Behavior, VA NCP



### MOVE! - Coming Soon!

Starting out like a lamb, *MOVE!* is coming out like a lion! NCP is delighted to report that progress is occurring at a frenetic pace. *MOVE!* is slated for its debut in January 2006, although approximately 50 VA sites have already started offering the program, or are actively involved in the process of implementing it. This is an outstanding accomplishment given the fact that there was no training package available, no clinical reference manual, no marketing materials, no way to easily put the computerized questionnaire reports into CPRS, and many other facets of the program were not yet completed. It is a tribute to the strength, dedication, and enthusiasm of the VA staff members who are implementing the program at this time. There is also a *MOVEmployee!* Program going on in Fargo ND, and plans afoot for more such programs in VISN 8.

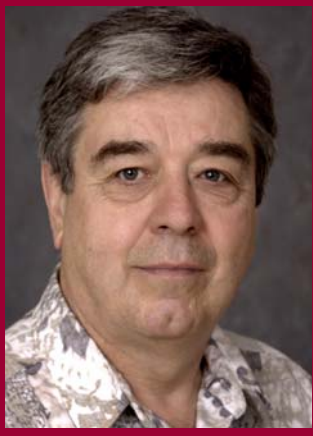
The *MOVE23!* Computerized Initial assessment questionnaire has been revised, as have both the patient and staff reports that result. The patient report remains rather lengthy (per feedback from patients), but the staff report is short and contains links to the applicable patient handouts. The reports may now be automatically ported into CPRS through a mechanism known as VistaWeb. Patients may now access the *MOVE23!* through the MyHealthVet website ([myhealth.va.gov](http://myhealth.va.gov)) or the *MOVE!* public website ([www.move.med.va.gov](http://www.move.med.va.gov)). A code printed on the patient report from these sites may be entered by staff on the VA *MOVE!* website ([vaww.move.med.va.gov](http://vaww.move.med.va.gov)). The patient's answers to the questionnaire are automatically transferred from the internet so that the staff report may be produced and saved in CPRS if desired. Cool!

Other progress is ongoing. Both VISN-level and facility-level *MOVE!* Coordinators have all been named, thus establishing a national network of enthusiastic leaders who will guide the implementation of the program throughout the VHA. NCP has worked with EES to complete a remarkably comprehensive web-based *MOVE!* training package. The training features separate tracks for different disciplines/groups, will offer continuing education credits, and will be available in October 2005. The data from all 17 *MOVE!* pilot sites is all in, and being analyzed. A final report will be forthcoming. A plan to evaluate *MOVE!* nationally is being developed.

The Quick Start Manual has been significantly revised and is available on the VA *MOVE!* website. It has brief descriptions of clinical information regarding the operation of the program, but also focuses on initial implementation strategies. A comprehensive Clinical Reference Manual is nearing completion and will be part of the *MOVE!* toolkit, as well as being posted on the website. The Reference Manual will be a much more complete compendium of clinical information related to weight control and physical activity. All of the patient handouts are currently being reviewed and revised as needed. A *MOVE!* toolkit will be distributed to Medical Centers and CBOC's in December 2005. It will include the Quick Start and Clinical Reference Manuals, sets of pocket guides for several different disciplines, posters, pamphlets, and numerous other marketing materials, program content on CD's, starter folders, certificates, *MOVE!* calendars, and stickers for patients, laminated BMI charts, 30 second video clips, a patient orientation video, staff orientation video, pedometers, and much more.

Draft versions of a weight management Directive, Handbook, and *MOVE!* Program Guide have been developed with input from the VISN Coordinators and others in the field. These documents are currently in the review and concurrence process in VA Central Office, and it is hoped that they will soon be signed by the Under Secretary for Health, Dr. Perlin. The Directive will mandate the provision of weight management services incorporating all population health and comprehensive care elements present in *MOVE!* In order to meet the intent of the Directive, sites may simply implement *MOVE!* or may blend parts of it with their ongoing weight management programs. NCP worked with the VA Bariatric Surgery Work Group to craft standards for bariatric surgery in VA. The Handbook on Criteria and Standards for Bariatric surgery has been approved and is now available on the NCP website at this link <http://vaww.nchpdp.med.va.gov/BariatricSurgery/BariatricSurgeryHandbook.doc>.

A *MOVE!* hotline for questions from VA staff has been established at 1-866-979-MOVE (6683), or the *MOVE!* team may be emailed at [http://vaww.move@med.va.gov](mailto:http://vaww.move@med.va.gov). Contact persons at the Center are Drs. Richard Harvey (919-383-7874, ext. 223) and Ken Jones (919-383-7874, ext. 228).



## Preventing Long Term Homelessness Using Work Therapy

**Bill Fullar, LMSW**  
**Homeless Action Center Coordinator**  
**VA Medical Center, Bronx, New York**

**I**f the length of time a veteran is without housing can be reduced, many serious health problems may be prevented. In FY 2004,

VA Health Care for Homeless Veterans Programs (HCHV) completed initial assessments on 42,485 veterans and 41% had been homeless for six months or more. At the Bronx HCHV program we have been a little above this national average, and we have found that veterans who are homeless often miss needed medical appointments, and are at higher risk for serious medical problems such as treatment resistant TB, hepatitis or HIV. They also lose social supports and vocational links and are at higher risk for incarcerations. Keeping the period of homelessness to a minimum can often prevent these serious health and social problems.

The HCHV program in the Bronx reaches out to local shelters and soup kitchens to try to get veterans engaged in needed treatment when they first become homeless. They have integrated homeless and vocational programs to provide work opportunities for veterans with short periods of sobriety. Addiction problems often keep veterans in shelters, and veterans living in shelters and on the streets often are not motivated to enter traditional treatment programs. Motivating them for treatment, however, is exactly what's needed if more serious problems are to be prevented. One thing that is appealing to this population is the opportunity to get a job and earn money, and in some cases, it may be the only way to intervene in this cycle that can lead to long-term homelessness.

HCHV can admit homeless veterans into work therapy with little sobriety and stability because they are fully integrated in the Mental Health Patient Care Center at the Bronx VA. Last FY, 30% of the veterans participating in the work therapy program had been homeless before entering the program. This program puts veterans in a supported

environment at a VA Medical Center where they earn about \$1000/month. They need a medical clearance to get into the program which gets them linked with a health care provider, and our medical center has arranged for these initial appointments to be within two weeks of their initial assessment. Last year 92% of the veterans who completed the work program obtained community employment. This employment allowed them to remain free of shelter living and homeless programs, and certainly led to healthier life styles. 55% of those individuals starting the program, completed it, and considering that the work program gives homeless and addicted veterans with only one month of sobriety \$1000/month, this rate compares very favorably with more traditional addiction programs.

In summary, work therapy rewards veterans who remain sober by allowing them to continue to earn an income. In many cases, veterans were not interested in drug or alcohol treatment until they learned that they could earn money by documenting the month of sobriety necessary to enter work therapy. The Bronx HCHV program works on the very basic principle that behavior that is rewarded is more likely to occur in the future. The program has witnessed much more retention and much better health care compliance and much more community reintegration than would be expected from homeless veterans having only a month of sobriety.

This article was reviewed by Jill E. Manske, ACSW, LISW, -  
 Director, Social Work Service, VA Central Office

***"The first step toward change is awareness. The second step is acceptance."***

*Nathaniel Branden - American Expert on Self-Esteem,  
 Author, Psychologist*

## **MOVE! Success Stories**

### **Anna Loeb, LPN Program Manager VA Medical Center, Fargo, ND**



From left to right; Anna Loeb, LPN Program Manager;  
Pam Wolf, PharmD; Kathy Reinecke, DPT; Connie Hayden, LRD

The *MOVEmployee!* Program at the Fargo VA offers two levels to the participants. Level One is self propelled and open ended. The employee meets with the *MOVE!* Project Manager to submit the *MOVE!* 23 questionnaire into a data base. At this time the participant chooses three goals to work on from the target areas: food and nutrition, exercise, and behavior. The Project Manager will follow up, via email, with the employee after one week and then once a month. At each follow-up encounter, *MOVEmployee!* materials are provided to assist the employee with meeting their goals. Level Two includes everything provided for Level One, as well as fourteen weeks of classes, three times a week, taught by professionals from the VA facility. The Food and Nutrition class is taught by a Nutritionist, Connie Hayden, LRD; exercise is taught by a Physical Therapist, Kathy Reinecke, DPT; and Behavior is taught by a Mental Health professional, Pam Wolf, PharmD.

Once the Level Two group completes the fourteen weeks of classes, they move back to Level One status and continue to be monitored and supported. The program has been received so well that the first class that graduated from Level One decided to continue meeting once a week and have labeled themselves the *MOVEmployee!* Step-Up Group.



If you're going to *MOVE!*, why not bring along your spouse? That's what's happening with employees at the Fargo VA, and some participants couldn't hide the results even if they tried! Since joining *MOVEmployee!* Level Two classes, which started in April of this year, Kent and Sheila Johnson have lost a combined weight of 70 pounds!

Sheila reports, "The *MOVEmployee!* Program got me moving! I knew what I needed to do, but with dietetic education, an exercise program and the support of the group I've lost 26 pounds and I'm on my way. The program has inspired my husband and I to pursue our goal of a healthier lifestyle." Kent can be seen in the newly released video highlighting the ease of using the *MOVEmployee!* materials and examples of some of unbelievable results that the participants are having.



Kent and Sheila Johnson

## Warned, but Worse Off

By STEVEN WOLOSHIN, LISA SCHWARTZ and H.GILBERT WELCH

Previously Published in the New York Times—August 22, 2005

Reprinted With Permission

*The following article is a well-written explanation of why screening tests need to be carefully evaluated before they are put into widespread use. The authors make several important points:*

1. *In screening tests, most initially "positive" results are false positives, subjecting many people to the inconvenience and worry and possible hazards of work-ups for no benefit.*
2. *Not all "true positives" are important to find (for example, the slow growing "cancers" that would never progress during a person's lifetime to cause symptoms) but it's hard to tell the difference in an individual patient and all patients usually get treated, as if the cancers are important.*
3. *Survival statistics CAN NOT be used to justify screening, as explained below, but it seems like it should be true and people, including many healthcare professionals, often use survival data as a reason for screening but those statistics don't answer the question of "does screening work?".*



**White River Junction, VT.** - Lung cancer seems to be the disease of the moment. The announcement that Dana Reeve, the widow of Christopher Reeve, has the disease - coming just two days after Peter Jennings died from it - has many Americans wondering if they should get tested with a CT scan. They should think twice. Wait, isn't CT screening one of those "quick and painless tests" that could save your life? And hasn't it been reported that people whose lung cancer is found early by such scans have a five-year survival rate of 80 percent, as opposed to 15 percent for the typical lung-cancer patient whose condition is detected later? Why not get scanned today?

The answer may surprise most Americans: we just don't know if lung cancer screening does more good than harm. While the benefits of screening

are unproven, the harms - one familiar, the other less so—are certain.

The familiar harm is caused by false alarms. CT scans are great at finding abnormal areas of the lung. But while relatively few people have lung cancer, many have other lung abnormalities. After a positive CT scan, many are biopsied, and most will turn out not to have cancer. A lung biopsy is not a trivial procedure. Although serious complications are rare, the procedure may result in hospitalization (largely for a collapsed lung), and there have been deaths.

The less familiar, but more worrisome, harm comes from overdiagnosis and overtreatment. In the largest study to date, Japanese researchers using CT scans found almost 10 times the amount of lung cancer they had detected in a similar group of patients using X-rays. Amazingly, with CT screening, almost as many nonsmokers were found to have lung cancer as smokers.

Given that smokers are 15 times as likely to die from lung cancer, the CT scans had to be finding abnormalities that were technically cancer (based on their microscopic appearance), but that did not behave in the way most people think of cancer behaving - as a progressive disease that ultimately kills. So here's the problem. Because we can't distinguish a progressive cancer from a

nonprogressive cancer on the CT scan, we tend to treat everybody who tests positive. Obviously, the patients with indolent cancers cannot benefit

from treatment; they can only experience its side effects. Treatment - usually surgery, but sometimes chemotherapy or radiation therapy - is painful and risky. Some 5 percent of patients older than 65 die following partial lung removal, and nearly 14 percent die with complete removal.

*(Continued on page 11)*

**We just don't know if lung cancer screening does more good than harm...**

(Continued from page 10)

But wait a minute. Don't those compelling five-year survival statistics of 80 percent vs. 15 percent prove that CT screening works? The short answer is no. You have to consider exactly how a five-year survival rate is figured. It is a fraction. Imagine 1,000 people diagnosed with lung cancer five years ago. If 150 are alive today, the five year survival is 150/1000, or 15 percent. Yet even if CT screening raised the five-year survival rate to 80 percent, it is entirely possible that no one gets an extra day of life.

The best way to understand this paradox is to work through a thought experiment. First, consider a group of people with lung cancer who will all die at age 70. If they first receive the diagnosis when they are 67, their five-year survival rate would be zero percent. But if these same people had received their diagnoses earlier - at, say, age 63 - the five-year survival rate would be 100 percent. Yet death would still come at 70 for all of them. Earlier diagnosis always increases the five-year survival statistic, but it doesn't necessarily mean that death is postponed.

A second thought experiment helps further understand why CT scans, which find so many minute, nonprogressive tumors, inflate survival rates. Imagine a city in which 1,000 people are found to have progressive lung cancer following evaluation for cough and weight loss. At five years after diagnosis, 150 are alive and 850 have died: a five-year survival rate of 15 percent. However, if everyone in the city were screened with CT scans, perhaps 5,000 would be given a cancer diagnosis, although 4,000 would actually have indolent forms. These 4,000 would not die from lung cancer in 5 years, and the five-year survival rate would increase dramatically - to 83 percent - because these healthy people would appear in both parts of the fraction: 4150/5000. But what has really changed? Some people have been unnecessarily told they have cancer (and may have experienced the harms of therapy), and the same number of people (850) still died.

This is exactly what was found in a randomized trial of chest X-ray screening at the Mayo Clinic -

five year survival was higher for those who were screened (35 percent vs. 19 percent) but death rates were in fact slightly higher in the screened group. Consequently lung cancer screening with chest X-rays is not recommended.

Someday we will know if CT lung cancer screens help more than they hurt (the results of a major National Cancer Institute trial will be available in about five years). But until then, everyone should know that screening is a two-edged sword.

Steven Woloshin, Lisa Schwartz and H. Gilbert Welch are physician researchers at the Department of Veterans Affairs and faculty members at Dartmouth Medical School.



Cartoon courtesy of Cagle Cartoons

**The Prevention Champion  
Award process is currently  
under review. Changes will be  
posted on NCP's website by  
October 31, 2005!**

VA National Center for Health Promotion  
and Disease Prevention  
3022 Croasdaile Drive, Suite 200  
Durham, NC 27705

**Putting Prevention Into Practice in the VA**